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Health and Welfare of Immigrants

Britain is a multiracial society. With such a close proximity to Europe and highly developed trading history, this country has always been concerned with the constant mixing together of peoples. In recent years, with the world-wide movement of people from rural to urban areas together with highly developed means of mass-media communication the problems associated with integration have been highlighted. Public health problems are beginning to settle down into their correct perspective as both central government and local authorities co-operate in planning and co-ordinating voluntary and statutory agencies for the positive integration of the immigrant family.

Statistics

Who are the immigrants? There is quite a large number of Irish, but it is impossible to find out how many, especially the number of children in care who are originally from the Republic of Eire. There are about 1¼ million coloured immigrants in Britain, 50% of whom have been here less than eight years, and there are just over 200,000 coloured children in British schools. It is estimated that there are 250,000 second generation immigrants in Britain already – in other words, 20% or 1 in 5 of the total immigrant population were actually born in Britain. The majority work in the transport, catering or building industries and the present state of the National Health Service is dependent upon immigrant doctors and nurses (Parry 1966). Most have found work relatively easy to obtain, but accommodation can be difficult as well as expensive and the immigrant is often left no choice but to live in overcrowded houses in multiple occupation. The Department of Health and Social Security (Chief Medical Officer 1967) issue pink cards in several languages giving information about NHS facilities which are given to immigrants on arrival in Britain, although many are slow in registering with general practitioners (Schwartz 1967).

About half of all the immigrants live in the South-east, and of immigrants from newer Commonwealth countries about two-thirds are living in the six major conurbations. There are 43% in Greater London, 8·6% in the outer metropolitan area, and 10% in the West Midlands. Of the 326,000 households in which the head or spouse was born in a newer Commonwealth country about one-third (118,000) share a dwelling. Of these more than a third (43,000) do not have the exclusive use of a stove or sink. More than 8,000 of the total 70,000 older Commonwealth households (11·4%) share a dwelling and 1,250 have to share a stove and sink. Rather less than half the new Commonwealth households (156,000) are in owner-occupied homes and 30,000 live in Council property. Half the old Commonwealth immigrants (35,000 households) own their own homes and 11,000 rent from local authorities. Only 11,000 men from the new Commonwealth are out of work, about the same percentage (3%) as for the old Commonwealth (Skone 1969).

Housing

Lack of knowledge of their rights and obligations under British law cannot but cause immigrants unnecessary concern and often leaves them wide open to exploitation. Security of tenure, rent control, the rent officer, rent tribunals, the need for legal advice when undertaking contracts of house purchase, the powers of local authorities to secure repairs and maintenance of rented properties, the Housing Act provisions empowering local authorities to require abatement of overcrowding, registration of houses in multiple occupation, and the securing of reasonable standards in such houses, are complex legal matters. If these were more simply explained preferably either by pamphlets in their language, and/or coloured liaison officers, then much worry and heartache to a harassed person settling in a strange country would be reduced. On the other hand, immigrants must be encouraged to take their problems to the town hall where much valuable advice and assistance can be obtained. Likewise, the town hall must recognize the problem of language communication and make the necessary arrangements.

Many families are unaware that, like every other British citizen, they are entitled to put their names down on a council housing waiting list. In general the qualification for the housing list should be one of need. The Ministry has, in fact, urged authorities to place a greater emphasis on this side of the problem (Rose *et al.* 1969).

Infectious Diseases

There is a relatively high incidence of tropical parasitic diseases in immigrants (Parry 1969). Hookworm (ankylostomiasis) is the most frequent helminth encountered, followed by roundworm (ascariasis) and whipworm (trichuriasis). Malaria, schistosomiasis, amœbiasis, filariasis, leprosy, yaws and trachoma, although present to a varying degree in a number of immigrants, are relatively innocuous from a public health point of view, although important to the individual sufferer. Smallpox is a constant risk, although

strict vigilance at both sea- and air-ports has reduced this danger to an acceptable minimum. Nevertheless, it would be naive to assume that there is not a serious hazard here when smallpox is endemic in Afro-Asian countries. Improved smallpox vaccine and WHO mass vaccination programmes will, in time, solve this problem. Salmonellosis, especially the enteric-fever variety (*S. typhi* and *S. paratyphi-B*), are common and constitute a serious risk among those employed in the food-handling trades. Recent typhoid and paratyphoid cases have been in newly-arrived coloured immigrants, holidaymakers and travellers from abroad.

It is clear that immigrants, here as everywhere, continue to make a contribution to the increasingly serious problem of venereal disease. But there are indications that, as the number of unaccompanied immigrant men decreases and those already here are joined by their families, the contribution they make to the total is relatively less. It should be noted that the proportion of men from abroad treated for infectious syphilis in England and Wales in 1966, as determined in the equivalent study for that year, was 50%, but in 1967 it fell to 39%. The figures for gonorrhœa in males were 45·4% in 1966 and 43·6% in 1967. The proportional contribution of immigrants to the incidence of this disease has fallen progressively since 1962, when it was 56% (*British Journal of Venereal Diseases* 1968).

Tuberculosis among immigrants amounts to a medical problem only in certain cities and towns in the North and Midlands and in the London area. A national survey of tuberculosis notifications in Britain carried out by the Medical Research Council in 1965 showed that 16·5% were immigrants, of whom 9·6% were born in India and Pakistan (British Tuberculosis Association 1966). Further analysis showed that persons born in India and now living in England and Wales had a notification rate 12 times greater than the rate for those born in Britain; and the notification rate for those born in Pakistan was 26 times greater than that for the British-born population of England and Wales. Primary drug resistance (Miller *et al.* 1966) is commoner among immigrants than among patients born in Britain or Ireland.

Child Welfare

Immigrant feeding patterns tend to be traditional, in particular infant feeding. The classical syndromes of kwashiorkor and marasmus are practically non-existent in the immigrant, but iron-deficiency anæmia and rickets are not uncommon (Dunnington *et al.* 1962, Benson *et al.* 1963). The cause of the anæmia is probably the prolonged feeding of cow's or breast milk, both containing minimum quantities of iron. Even after weaning onto solid food many immigrant children depend largely on milk for their protein requirements, and the rest of the diet is made up with carbohydrate foods, e.g. rice, bread, potatoes, green bananas and yams (Stroud 1965). Sickle cell anæmia is not uncommon in children of negro origin, while thalassæmia is seen in many Asian countries (Beard & Signey 1965).

Rickets has been reported in numerous instances in West Indian, Pakistani, Greek Cypriot, and Irish children as well as in Scottish children in Glasgow (Dunnington *et al.* 1962). The common feature in every case has been the fact that the children have been fed for long periods on breast milk or cow's milk without any supplementary vitamins. When a Pakistani community in Glasgow (74 adults and children) was examined in 1962, 35 showed evidence of rickets (Dunnington *et al.* 1962). Since then, other workers (Arneil & Crosby 1963, Dunnigan & Smith 1965), have found widespread vitamin D deficiency in similar child groups. Arising from detailed surveys, it has been discovered that many immigrant children are cared for by unauthorized child minders (Stroud 1965). They are commonly fed on cow's milk during the day and on the mother's breast milk morning and evening. Supplementary vitamins and other foods have rarely been given.

Health visitors devote much time to immigrants and in some local health authorities this amounts to a third of their time. (Galloway 1967). As a result of language difficulties they may have to revisit Asian wives when husbands are at home or when the children are back from school. Often families rapidly change address which means delay in tracing them, while mothers may have returned to work having left the child with an unregistered minder. In particular, burns are an extremely dangerous and common problem. In certain London hospitals immigrant children often comprise up to 40% of cases admitted (Stroud 1965). Paraffin oil heaters are the most common form of cheap heating used, with as many as 95% of families using them; paraffin poisoning due to children drinking the fuel by mistake is not uncommon. Repeated warnings in press and television have not had much effect and this is a great hazard.

Health education both at the clinic and individually by the health visitor or social worker is invaluable especially when simply-worded pamphlets in their own language supplement the advice given. Classes in basic Afro-Asian languages

designed for European nurses have been arranged in many areas, which should help to break down language barriers.

School Children

Many of the non-English speaking Asian children in Britain come from the rural areas of Pakistan and India. They come from homes where the women are in purdah and the mixing of sexes after puberty is strictly forbidden. The Indian children are mainly Sikhs from the Punjab who have strong family codes for respecting their parents. Many may have had no experience of school life. The West Indian child may be restricted by the crowded conditions in which he now lives and is upset by the less formal approach to education in British schools which he may interpret as a sign of weakness. This is further emphasized by the fact that he has to face the traditional discipline of the West Indian at home. Those from Jamaica are usually from the Jamaican upper lower-class and many have lived in rural, often remote, areas with little or no contact with white people and they tend to regard English people with a mixture of mistrust and respect.

Psychologically, both the West Indian and Asian school child are often unprepared for living in Britain. The child's greatest task may be the re-establishment of a relationship with his parents. Both parents may go to work and he may feel acutely the lack of social support that he enjoyed in his recently-left country, while his parents may be both shocked and disappointed at the child's social behaviour and academic shortcomings. Feelings of insecurity in England and the difference between home and school discipline may cause conflict in the child even after the initial period of adjustment is over.

The large influx of immigrant children has brought extreme pressure to bear on the already overcrowded school accommodation in Northern and Midland towns (Skone 1968), and it has been necessary for a complete re-appraisal of teaching methods for teachers with immigrant classes.

Maternity Services

The majority of female immigrants to Britain are young, fertile and as a group have a high birth-rate. More than half the illegitimate babies are now born to immigrants. In centres such as Wolverhampton (Galloway 1967) and Bradford (Dolton 1966) immigrant mothers accounted for 23% and 10% of births respectively in 1966. While 75% of these coloured immigrants in Bradford are confined in hospital, higher percentages (90% and 95%) were recorded in Wolverhampton (Galloway 1967) and Sheffield (Parry 1966). Despite such high standards of hospital confinements, babies born to West Indian and Asian mothers have a higher still-birth and perinatal death-rate than those born to British parents (Dolton 1968). The unsatisfactory home conditions under which many of them live place an additional heavy load on maternity unit admissions. Domiciliary midwives may have to make twice as many antenatal visits owing to difficulties in persuading immigrants (in particular those from India) to prepare for their confinement. Language problems are time-consuming as so few speak or understand English and coloured midwives who are of the same nationality are rare. In immigrant areas of population, it is interesting to note that increasing numbers are attending family planning clinics, nearly half of whom are West Indians (Skone 1968). As prejudice is overcome and better facilities become available it is expected that many more will seek family-planning advice.

Hookworm anæmia amongst pregnant coloured immigrants attending local authority antenatal clinics is a particular problem. In Sheffield over a two-year period (Parry 1969), 521 expectant mothers were seen of whom 229 (44%) gave stool specimens; 41 had helminth infestation, 26 for hookworm, seven for whipworms and eight combined hookworm and whipworm. All were referred for treatment to either their own family doctor or hospital.

Children in Care

Many West Indian mothers, who from necessity go out to work, especially if deserted by their husbands, are inclined to leave their children rather haphazardly with relatives and friends. In addition, many of the 'single' West Indian men have married or associated with unstable and often subnormal white girls. These associations may terminate when their families join them or they decide to change partners. This has resulted in a large number of coloured or half caste children coming under the care of local authority children's departments in the last few years (Parry 1966).

Coloured children under five have less chance of growing up to be integrated, happy, well-adjusted adults than their English counterparts (Davies 1967), because for those who come from a tradition and culture which may be quite different to that of Britain – West Indian, African, Indian or Pakistani – it may follow that a long period in a British children's home puts additional obstacles in the way of their eventual return, rehabilitation, and reintegration with their own family. Though they may grow isolated from their own cultural background, their colour may still prevent them

from being fully accepted in a non-Indian or non-West Indian community and in that way finding a secure place for themselves in that community and in the world in general. There is the difficulty of finding adopters and foster parents for coloured children. This means their chances of being placed with families are rather limited. Children generally in care often manifest signs of the deprivation syndrome and coloured children in particular are especially at risk in having psychological problems about being racially different from the majority, although this does not seem to apply to all of them.

It has been my experience that the young Arab child is much more easily boarded out whereas 'full-blooded' West Indian children are the most difficult. A national campaign is needed to board out many more immigrant children with foster parents of their own nationality (Davies 1969).

Conclusion

Most immigrants will want to stay in Britain and become fully integrated. They will be aided and their status and image of themselves raised by knowledge and respect for their own individual cultural background. We need to cultivate the tolerance to coloured immigrants that one finds in Holland, France and New Zealand. This will not be achieved until we make available as top priority adequate housing accommodation. Local authorities should examine their allocation arrangements with the plight of the coloured immigrant placed in its proper perspective. Adult Asian immigrants should be X-rayed on arrival with compassionate arrangements for those found to be infected. Ideally, pre-admission medical examinations, including chest X-rays should be carried out in their country with appropriate treatments and hospitalization at that stage. In 1967, over 20,000 Commonwealth citizens were medically examined on entry, of whom 58 were refused entry on medical grounds (Institute of Race Relations 1969). In 1967, consultations continued between British missions overseas and Commonwealth governments about arrangements for the medical examination of prospective Commonwealth immigrants in their country of origin, and arrangements were concluded in 27 territories (Chief Medical Officer 1968).

In those areas with immigrant populations, there should be more staffed maternity beds together with integrated voluntary and local authority family-planning services. There is urgent need for more adequate play and registered child-minding facilities with pre-school groups and day nurseries. The government's urban-aid programmes are assisting those areas with the highest immigrant problems. Voluntary organizations and industry should be encouraged to supplement local authority arrangements and plans. Many progressive local authorities have set up committees to examine the problems of community relations. These are doing exemplary work in encouraging spontaneous integration and acceptance of the immigrant into the community.

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